

***Cigna Dental Benefit Summary
Rutherford County Employee Benefit Trust
DPPO Option 2***



All deductibles, plan maximums, and service specific maximums (dollar and occurrence) cross accumulate between in and out of network.

Cigna Dental PPO

Network	Total Cigna DPPO		Out-of-Network	
Calendar Year Maximum (Class I, II and III expenses)	\$1,000		\$1,000	
Annual Deductible Individual Family	\$50 per person \$150 per family		\$50 per person \$150 per family	
Reimbursement Levels**	Based on Reduced Contracted Fees		90th percentile of Reasonable and Customary Allowances	
Balance Billing by Dentist in excess of Coinsurance	No		Yes	
Benefits	Plan Pays	You Pay	Plan Pays	You Pay
Class I - Preventive & Diagnostic Care Oral Exams Cleanings Routine X-rays Fluoride Application Sealants Space Maintainers (limited to non-orthodontic treatment)	100%	No Charge	100%	No Charge
Class II - Basic Restorative Care Non-Routine X-Rays Emergency Care to Relieve Pain Fillings Oral Surgery - Simple Extractions	80% *	20% *	80% *	20% *
Class III - Major Restorative Care** Oral Surgery - All Except Simple Extraction Surgical Extraction of Impacted Teeth Anesthetics Major Periodontics Minor Periodontics Root Canal Therapy / Endodontics Relines, Rebases, and Adjustments Repairs - Bridges, Crowns, and Inlays Repairs - Dentures Crowns / Inlays / Onlays Dentures Bridges	50% *	50% *	50% *	50% *
Class IV – Orthodontia** Annual Deductible Lifetime Maximum	50% * \$50 \$1,000 Dependent children to age 19	50% *	50% * \$50 \$1,000 Dependent children to age 19	50% *

Missing Tooth Limitation—Teeth missing prior to coverage under the Cigna Dental plan are not covered. Pretreatment review is available on a voluntary basis when extensive dental work in excess of \$500 is proposed.

* Subject to annual deductible

**12 month waiting period for Class III and Class IV

Dental Oral Health Integration Program (OHIP) - All dental customers = Clinical research shows an association between oral health and overall health. The Cigna Dental Oral Health Integration Program (OHIP)® is designed to provide enhanced dental coverage for customers with certain eligible medical conditions. Eligible conditions for the program include cardiovascular disease, cerebrovascular disease (stroke), diabetes, maternity, chronic kidney disease, organ transplants, and head and neck cancer radiation. The program provides:

- 100% coverage for certain dental procedures
- guidance on behavioral issues related to oral health
- discounts on prescription and non-prescription dental products

For more information and to see the complete list of eligible conditions, go to www.mycigna.com or call customer service 24/7 at 1.800.CIGNA24.

**For services provided by a Cigna Dental PPO network dentist, Cigna Dental will reimburse the dentist according to a Contracted Fee Schedule. For services provided by an out-of-network dentist, Cigna Dental will reimburse according to Reasonable and Customary Allowances but the dentist may balance bill up to their usual fees.

Cigna Dental PPO Exclusions and Limitations

Procedure	Exclusions and Limitations
Late Entrants Limit	No Coverage for 12 months
Exams	1 per 6-month consecutive period.
Prophylaxis (Cleanings)	1 routine prophylaxis or perio maintenance procedure per 6-month consecutive period (routine prophylaxis is Class I; perio prophylaxis is Class II).
Fluoride Treatments	1 per consecutive 12 months for participants younger than age 14.
Histopathologic Exams	Payable if the biopsy is covered. No coverage for other diagnostic tests.
X-rays (routine)	Bitewings: 1 set in any consecutive 12 month period. Limited to a maximum of 4 films per set.
X-rays (non-routine)	Full mouth or Panorex: 1 per 60 consecutive months.
Periapical x-rays:	4 in 12 consecutive months if not performed in conjunction with an operative procedure.
Intraoral occlusal x-rays:	2 in 12 consecutive months.
Models	Not covered.
Fillings	1 per tooth per 12 consecutive months (applies to replacement of identical surface fillings only). No composite, white/tooth colored fillings on bicuspid or molar teeth.
Sealants	1 treatment per tooth per lifetime. Payable on unrestored permanent bicuspid or molar teeth only.
Minor Perio (non-surgical)	Root planing-1 per quadrant per 36 consecutive months.
Perio Surgery	1 per 36 consecutive months per area of the mouth (same service).
Crowns and Inlays	Replacement limited to 1 per 84 consecutive months. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges. Replacement must be indicated by major decay. For participants less than age 16, benefits for crowns and inlays are limited to resin or stainless steel.
Stainless Steel & Resin Crowns	1 per 36 consecutive months for participants younger than age 16.
Bridges	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth-colored material on molar crowns or bridges.
Dentures and Partial	Replacement limited to 1 per 84 consecutive months, if unserviceable and cannot be repaired.
Relines, Rebases	Covered if more than 12 months after installation; 1 per 36 consecutive months.
Adjustments	Covered if more than 12 months after installation; 1 per 12 consecutive months.
Repairs - Bridges	Covered if more than 12 months after installation.
Repairs - Dentures	Covered if more than 12 months after installation.
Endodontics	Root canal re-treatment 1 per 24 consecutive months, if necessity demonstrated.
Prosthesis Over Implant	1 per 84 consecutive months if unserviceable and cannot be repaired. Benefits are based on the amount payable for non-precious metals. No porcelain or white/tooth colored material on molar crowns or bridges.
Alternate Benefit	When more than one covered Dental Service could provide suitable treatment based on common dental standards, Cigna HealthCare will determine the covered Dental Service on which payment will be based and the expenses that will be included as covered expense.

Benefit Exclusions:

- Services performed primarily for cosmetic reasons; Replacement of a lost or stolen appliance;
- Initial placement of a full or partial denture unless it includes the replacement of a functioning natural tooth extracted while the person is covered under this plan; removal of only a permanent third molar will not qualify for an initial or replacement denture or bridge;
- Overdentures, personalization, precision or semi-precision attachments;
- Replacement of a bridge, denture or crown within 84 months following its initial date of insertion;
- Replacement of a bridge, denture or crown which can be made useable according to dental standards;
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of
- TMJ, stabilize periodontally involved teeth, or restore occlusion, the restoration of teeth which have been damaged by erosion, attrition or abrasion; bite registration; or bite analysis;
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars;
- Core buildup, labial veneers; Precious or semi-precious metals for crowns, bridges, pontics and abutments; crowns and bridges other than stainless steel or resin for participants under 16 years old;
- Bite registrations; precision or semi-precision attachments; splinting;
- Surgical implant of any type;
- Instruction for plaque control, oral hygiene and diet;
- Dental services that do not meet common dental standards; Services that are deemed to be medical services;
- Services and supplies received from a hospital;
- Procedures for which a charge would not have been made in the absence of coverage, for which the person is not legally required to pay;
- Charges made by a hospital which performs services for the U.S. Government if the charges are directly related to a condition connected to a military service;
- Experimental or investigational procedures and treatments; Procedures which are not necessary and which do not have uniform professional endorsement;
- Any injury resulting from, or in the course of, any employment for wage or profit; Any sickness covered under any workers' compensation or similar law;
- Charges in excess of the reasonable and customary allowances;
- IV sedation or general anesthesia, except when medically or dentally necessary and when in conjunction with covered complex oral surgery;
- Fees charged for broken appointments, claim form submission or sterilization;
- Services not included in the list of covered dental expenses, unless Cigna HealthCare agrees to accept such expense as a covered dental expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;
- Crowns, inlays, cast restorations, or other laboratory prepared restorations on teeth unless the tooth cannot be restored with an amalgam or composite resin filling due to major decay or fracture; Replacement of teeth beyond the normal complement of 32;
- Prescription drugs; Athletic mouth guards; Myofunctional therapy;
- Charges for travel time; transportation costs; or professional advice given on the phone;
- Procedures performed by a Dentist who is a member of the covered person's family (covered person's family is limited to a spouse, siblings, parents, children, grandparents, and the spouse's siblings and parents);
- Any procedure, service, or supply which may not reasonably be expected to successfully correct the covered person's dental condition for a period of at least three years, as determined by Cigna HealthCare; Temporary, transitional or interim dental services; Diagnostic casts, diagnostic models, or study models;
- Any charge for any treatment performed outside of the United States other than for Emergency Treatment (any benefits for Emergency Treatment which is performed outside of the United States will be limited to a maximum of (\$100.00-\$200.00) per 12 consecutive month period);
- Procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;
- Any charges, including ancillary charges, made by hospital, ambulatory surgical center or similar facility;
- To the extent that payment is unlawful where the person resides when the expenses are incurred;
- For charges which would not have been made if the person had no insurance; For charges for unnecessary care, treatment or surgery;
- To the extent that you or any of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
- To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law. Cigna HealthCare will take into account any adjustment option chosen under such part by you or any one of your Dependents.

Services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared.

This benefit summary highlights some of the benefits available under the proposed plan. A complete description regarding the terms of coverage, exclusions and limitations, including legislated benefits, will be provided in your insurance certificate or plan description.

DPPO insurance coverage is set forth on the following policy form numbers: AR: HP-POL77; CA: HP-POL57; CO: HP-POL78; CT: HP-POL58; DE: HP-POL79; FL: HP-POL60; ID: HP-POL82; IL: HP-POL62; KS: HP-POL84; LA: HP-POL86; MA: HP-POL 63; MI: HP-POL88; MO: HP- POL65; MS: HP-POL90; NC: HP-POL96; NE: HP-POL92; NH: HP-POL94; NM: HP-POL95; NV: HP-POL93; NY: HP-POL67; OH: HP-POL98; OK: HP-POL99; OR: HP-POL68; PA: HP-POL100; RI: HP-POL101; SC: HP-POL102; SD: HP-POL103; TN: HP-POL69; TX: HP-POL70; UT: HP-POL104; VA: HP-POL72; VT: HP-POL71; WA: POL-07/08; WI: HP-POL107; WV: HP-POL106; and WY: HP-POL108.

“Cigna,” the “Tree of Life” logo and “Cigna Dental Care” are registered service marks of Cigna Intellectual Property, Inc., licensed for use by Cigna Corporation and its operating subsidiaries. All products and services are provided by or through such operating subsidiaries and not by Cigna Corporation. Such operating subsidiaries include Connecticut General Life Insurance Company (CGLIC), Cigna Health and Life Insurance Company (CHLIC), Cigna HealthCare of Connecticut, Inc., and Cigna Dental Health, Inc. and its subsidiaries. Cigna Dental PPO plans are underwritten or administered by CGLIC or CHLIC, with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries. In Arizona and Louisiana, the insured Dental PPO plan offered by CGLIC is known as the “CG Dental PPO”. In Texas, the insured dental product is referred to as the Cigna Dental Choice Plan. Cigna Dental Care (DHMO) plans are underwritten or administered by Cigna Dental Health Plan of Arizona, Inc., Cigna Dental Health of California, Inc., Cigna Dental Health of Colorado, Inc., Cigna Dental Health of Delaware, Inc., Cigna Dental Health of Florida, Inc., **a Prepaid Limited Health Services Organization licensed under Chapter 636, Florida Statutes**, Cigna Dental Health of Kansas, Inc. (Kansas and Nebraska), Cigna Dental Health of Kentucky, Inc., Cigna Dental Health of Maryland, Inc., Cigna Dental Health of Missouri, Inc., Cigna Dental Health of New Jersey, Inc., Cigna Dental Health of North Carolina, Inc., Cigna Dental Health of Ohio, Inc., Cigna Dental Health of Pennsylvania, Inc., Cigna Dental Health of Texas, Inc., and Cigna Dental Health of Virginia, Inc. In other states, Cigna Dental Care plans are underwritten by CGLIC, CHLIC, or Cigna HealthCare of Connecticut, Inc. and administered by Cigna Dental Health, Inc.